

DEPENDENT CARE REIMBURSEMENT CLAIM

STATE OF WASHINGTON DEPARTMENT OF RETIREMENT SYSTEMS

For questions, please call DCAP customer service at 360-664-7005 (in the Olympia area) or toll-free at 1-800-423-1524 and select option 4.

P.O. Box 40931 • Olympia. WA 98504-0931 • www.drs.wa.gov

1.6. Dox 40001 Glympia, WY 00004 0001 Www.dis.wa.gov					
Please type or prin	nt in dark ink. Attach bill, rec	eipt, invoice or comp	olete Section Three Provi	der Information and	return completed form to DRS.
Section One:	Personal Information				
Name			SSN		
Change Last	First	M.I.			
Address	Work Phone				
Change Number	Street				
			Uomo Dh	one	
Home Phone					
Section Two:	Expenses Incurred (S	ee Reimbursen	nent Claim Form Ins	structions)	
Date of Birth	Dependent Name (L	ast, First, MI)	From (mm/dd/yyyy)	To (mm/dd/yyyy)	Amount
		,, ,	(,		
Section Three	: Provider Information	n (Required, if y	ou are not submitt	ing a bill, receip	ot or invoice)
Name					
Address Cit		City	State	Zip	
	ided the dependent care ser		•		
r certify that I prov	ided the dependent care ser	vices indicated on ti	iis ioiiii.		
X Desiridar Cirnatura					
Provider Signature Date Section Four: Certification					
Section Four:	Certification				
	ed above will qualify as a depender kindergarten or above.	nt on my federal income	tax return for the current year.	(If not, I have attached a	a statement of explanation.) These
• These expenses were necessary to allow me to work, and if married, to allow my spouse to work or to be a full-time student.					
• My provider is not a dependent of mine and if my provider is a child of mine, that child will be at least age 19 as of the close of the current year.					
The expenses claims dependents have rec	ed above are eligible for reimburse eived reimbursement for these cla	ment under the Depende imed expenses from this	ent Care Assistance Salary Re s Dependent Care Program or	eduction Program and ne another source.	ither I, nor my spouse, nor my
I understand any clai	m for which I am reimbursed cann	ot also be used for feder	al child and dependent care in	ncome tax credit purpose	S.
I hereby certify that all	of the information I have entered	on this form is true and o	complete:		
, ,			•		
X				Please sen	d Reimbursement Forms
Signature of Emplo	•		Date		
FOR FASTER SERVICE			FOR DCAP USE ONLY		
Place this label on your return envelope		From	То	Approved Expenses	
DEDART: 4		140			· ·
DEPARTMENT OF RETIREMENT SYSTEMS DEPENDENT CARE ASSISTANCE PROGRAM					
P.O. BOX 40931					
	WA 98504-0931				